Diseases of the Mind

CLASS 15 TITLES

OF THE

DIAGNOSTIC NOMENCLATURE

NAVMED 1141

JULY 1947

BUREAU OF MEDICINE AND SURGERY
NAVY DEPARTMENT
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GENERAL CONSIDERATIONS

The very nature of psychiatric illness creates special problems in history taking and examination. Frequently the patient is unaware of the abnormalities of his behavior or is unable to relate his complaints because of embarrassment, suspicion, or confusion.

Patience is required in order to elicit significant information which at first may be withheld. To an even greater degree than in bodily illness there is need for true interest and sympathetic understanding on the part of the medical officer.

The factors which influence behavior are numerous, personality attributes vary over a wide range, and the dividing line between various disease entities is not always clear-cut. The terminology used in the naval service may differ in some respects from that used in civil practice. The recording of direct observations of the patient and the findings of mental examination are of paramount importance. When the patient has recovered to the degree that his separation from the service is considered, usually his symptoms have disappeared and in this improved condition he is often a poor historian with regard to an authentic description of his former behavor. Entries in the health record which state that the patient had paranoid ideas, bizarre behavior, ideas of reference, etc., are of much less value than a concise statement of an example of such behavior or thought content.

A social service report is frequently necessary in order to obtain a history of the patient's past behavior and personality from sources other than himself. In outlying stations the difficulty of obtaining such a verified history constitutes a handicap, and therefore additional care is necessary in order to establish a diagnosis. The establishment of a definitive diagnosis may have to be delayed until an authenticated history can be obtained. In all instances it is important for the medical officer who first interviews the patient to record information regarding the precipitating factors and the circumstances under which the symptoms first appeared. This history will require questioning of shipmates and an estimate of the patient's adjustment to others, his work record, etc. In foreign stations and combat areas this is particularly important. It is helpful to include, when possible, an opinion of the man's abilities and personality before he became ill, the probable importance of situational factors, and an estimate of his functional

capacities and prognosis. If information is lacking, or if the period of observation and the time for adequate examination are necessarily short due to the exigencies of the situation, this fact should be recorded.

Medico-legal considerations are frequently of importance in association with psychiatric disabilities. This possibility must be borne in mind and particular care should be taken to obtain and record authentic and relevant information.

The establishment of a diagnosis of a psychosis requires the clear statement of the reasons for the diagnosis, so that the true nature of the illness can be evaluated even if at a later date the psychotic symptoms subside. A psychotic diagnosis should not be established on presumption, nor should it be utilized in the event of doubt. If there is a doubt as to the nature of the illness and if the medical officer wishes to insure proper surveillance of a questionably psychotic patient, or non-psychotic patient requiring supervision, this should be accomplished by a written statement indicating the type of supervision required. Such terms as "the patient exhibits psychotic symptoms" should be avoided. A description of these symptoms and of the circumstances will be of greater assistance to the medical officers who will subsequently care for the patient.

15xy. ***Other diseases of this class.*** **State title.**
1501. Psychosis With Infectious Disease. State disease.
1502. Psychosis With Meningo-vascular Syphilis.
1503. Psychosis With Tabes Dorsalis.
1504. Dementia Paralytics. (*Paresis*)
1505. Psychosis, Alcoholic.
1512. Psychosis, Drug. State drug.
1513. Psychosis. *Other exogenous toxins.* State toxin.
1514. Psychosis, Epileptic.
1515. Psychosis, Traumatic.
1516. Psychosis With Organic Brain Disease.
1517. Psychosis, Senile.
1518. Psychosis With Other Somatic Disease. State disease.
1521. Psychosis, Manic-depressive.
1522. Schizophrenia. (*Dementia Praecox.*)
1523. Paranoia.
1524. Paranoid State.
1525. Psychosis With Psychopathic Inferiority.
1526. Psychosis With Mental Deficiency.
1527. Psychosis. *Otherwise unclassified.*
1531. Reactive Depression.
1541. Psychoneurosis, Anxiety.
1542. Psychoneurosis, Hysteria.
1543. Psychoneurosis, Obsessive-compulsive.
1544. Psychoneurosis, Neurasthenia.
1545. Psychoneurosis. *Otherwise unclassified.*
1561. Personality Disorder.
1562. Schizoid Personality.
1563. Constitutional Psychopathic Inferiority.
1564. Pathologic Sexuality.
1571. Speech Disorder.
1572. Alcoholism, Chronic.
1573. Enuresis. (*Bed-wetting.*)
1574. Somnambulism.
1581. Mental Deficiency.

1501. Psychosis With Infectious Disease (state disease)

The designation is identical with the category formerly coded 1528, except for the addition of "State disease"; for example *Psychosis With*

Infectious Disease (*Malaria*) *1501.* Psychoses classified in this group are always associated with febrile diseases, such a typhoid fever, malaria, etc. Generally it is advisable to retain the diagnosis of the basic organic disease when the psychotic manifestations occur merely as coincidental symptoms, e. g., the toxic delerium of pneumonia. However, if the management of the psychosis assumes primary importance, for instance, when transfer to a mental hospital for institutional care becomes necessary, the diagnosis should be changed to *Psychosis With Infectious Disease.*

1502. Psychosis With Meningo-vascular Syphilis

This category should be reserved for patients in whom the clinical picture of *Dementia Paralytica* (*Paresis*) is not present, but the history of vascular symptoms and spinal fluid findings indicate predominant involvment of the meninges and blood vessels. The clinical picture characteristic of this disease process consists of an early onset of symptoms after infection, an acute episode of confusion and delerium with focal neurological signs, and a high fluid cell count, spinal. In these patients the spinal fluid serology is frequently negative while the blood serology is usually positive. When the psychotic behavior and neurological findings are believed to be on a vascular basis and due to syphilis, this diagnosis should be established. Psychosis associated with syphlitic meningo-myelitis and the rare case of gumma should be classified here.

1503. Psychosis With Tabes Dorsalis

In this category should be classified patients who have a psychosis due to syphilis, associated with the neurological signs of tabes dorsalis, but in whom the signs and symptoms of *Dementia Paralytica* (*Paresis*) are not present.

1504. Dementia Paralytica (*Paresis*)

This title is identical with the category previously coded 1215. Here should be classified those patients who show progressive intellectual and emotional defects with physical signs and symptoms of parenchymatous involment of the central nervous system due to syphilis. The majority of these patients will show positive spinal fluid serology and a paretic type of gold curve. However, previous antisyphilitic treatment may modify these findings. Other cardinal findings are: perioral tremor, slurring of speech, Argyll Robertson pupils, mood disturbances (euphoria, apathy, or depression), intellectual and moral deterioration, and frequently delusions of grandeur.

1511. Psychosis, Alcoholic

This is identical with the category formerly coded 1522, except for the omission of the word "intoxication." The criterion for this diagnosis is that the psychosis be attributable to alcohol. Care must be exercised to determine that the psychotic symptoms are not merely the result of an exacerbation or an unmasking of more basic psychopathology by the ingestion of alcohol. The possibility should be considered that the consumption of alcohol may be symptomatic of a latent or cryptic depression, or an expression of confusion, or prompted by paranoid ideas. For medico-legal reasons it is important to ascertain the specific underlying circumstances in each case. The subdi-

visions are delirium tremens, acute hallucinosis, and Korsakoff's syndrome.

Delirium Tremens is characterized by the relatively acute appearance of increasing motor restlessness and emotional instability with rapidly developing delirium associated with bizarre visual hallucinations, clouding of the sensorium, defects of attention, marked tremors, and variable degrees of physical prostration, anxiety, and restlessness. Recovery generally occurs within a week or two.

Acute Hallucinations is characterized by the appearance of auditory hallucinations developing after the prolonged and excessive use of alcohol, and accompanied by a pronounced mood change of fear and apprehension. The hallucinations are usually accusatory and threatening and a delusional system is rapidly acquired. In many cases the effects of alcoholic intoxication may reveal for the first time an underlying schizophrenic process. In such cases the diagnosis of psychosis alcoholic should not be used.

Korsakoff's Syndrome.—This symptom complex is of relatively long duration and is characterized by intellectual retardation. It may be of nonalcoholic origin. The major defect is in the field of memory and is frequently filled in by confabulation. Objective symptoms and findings often include those of polyneuritis and other physical signs indicative of a vitamin deficiency.

1512. Psychosis, Drug (state drug)

Here should be classified those psychoses attributable to such drugs as cocaine, bromides, opium derivatives, acetanilid, barbituric acid derivatives, amphetamine sulphate, etc. The psychotic reaction is usually characterized by a toxic delirium which subsides within a relatively short period of time following the withdrawal of the etiological agent. As in the case of alcohol, the possibility that the use of the drug may be symptomatic of an underlying psychotic disorder should be considered.

1513. Psychosis, Other Exogenous Toxins (state toxin)

In rare instances psychotic symptoms may be precipitated by acute or chronic poisoning with lead, arsenic, mercury, poisonous gases, industrial compounds (carbon disulphide, methyl alcohol), and other metals and poisons. As in the case of infectious disease with delirium, it is preferable to classify the basic conditions as one of poisoning even when signs of a toxic delirium are associated. If the psychotic condition is protracted or when a change in diagnosis is necessary for reasons of transfer to a mental institution or for other legal purposes, the use of this title is indicated.

1514. Psychosis, Epileptic

In an occasional case of idiopathic epilepsy a psychiatric picture of intellectual deterioration will appear, with changes in the sensorium, pathological mood disturbances, hallucinations, and suicidal or homocidal tendencies. Such cases should be designated by this title. Care should be taken to distinguish between an epileptic psychosis and other psychoses occurring coincidentally with idiopathic epilepsy.

1515. Psychosis, Traumatic

In this category should be classified only those rare psychoses which, after careful study, appear to have been caused by physical injury to

the brain. Occasionally the onset of schizophrenia, manic depressive psychosis, or paresis may be precipitated by trauma to any part of the body, or attention may be called to the patient's mental status for the first time because of the trauma. Such cases should be classified according to the nature of the psychosis and not necessarily diagnosed *Psychosis, Traumatic* merely because of the coexistence of trauma.

The instances of traumatic delirium frequently seen following head injury may be classified here if it is necessary to use a psychotic diagnosis. However, it is preferable to diagnose the basic condition (i. e. *Intercranial Injury*) when the delirium is merely one of many symptoms of the fundamental disturbance.

1516. Psychosis With Organic Brain Disease

This classification should be used to designate those psychotic reactions which result from cerebral vascular disease, brain tumor, multiple sclerosis, encephalitis, paralysis agitans, Huntington's Chorea, and other organic diseases of the central nervous system.

1517. Psychosis, Senile

Here should be classified those psychoses which occur in old age, characterized by a loss of memory for recent events, mood swings, disorientation, difficulty in assimilation of new experiences, childishness, preoccupation with reminiscence, and loss of insight and judgment.

1518. Psychosis With Other Somatic Disease (state disease)

The presence of psychotic symptoms appearing in the course of somatic disease occasionally may necessitate specific designation. These disorders may occur in the presence of vitamin deficiency states, carcinoma disorders, cardiac decompensation, diabetes mellitus, etc.

1521. Psychosis, Manic Depressive

There are two general phases of *Manic Depressive Psychosis*, the elated and the depressed phase. The elated or manic phase is characterized by expansiveness, physical and mental overactivity, impairment of judgment, and lack of judgment. In hypomania, the acceleration and intensity of physical and mental activity are less marked and the psychotic nature of the patient's overactivity may be unrecognized. Attention may be drawn to the patient because of his aggressiveness in proposing new ideas, by his undue exhibition of energy and enthusiasm, or because of irritability and antagonism when he is frustrated in his overly ambitious projects.

These individuals are sometimes able to make very good impressions on many people by their positive manner, good humor, enthusiasm, and by pseudo-logical arguments. An outstanding characteristic of the hypomanic patient is the lack of insight regarding his own overactivity and impairment of judgment. Information regarding the patient's unusual personality is necessary in order to evaluate his current behavior, especially in borderline cases. Specific inquiry should be made regarding history of periods of elation, variability of mood, or episodes of depression.

The depressed phase of *Psychosis, Manic Depressive*, is characterized by lack of interest, loss of sense of humor, retardation, and feelings of guilt, unworthiness, and futility. Frequently there occur unreasonable and fixed delusions regarding disintegration of the body,

or irreparable damage to the stomach, brain, etc. Variable degrees of agitation and anxiety are seen. Mild depressions of this type are frequent and their proper evaluation is important because of suicidal tendencies which may be unrecognized, as the patient is able to "cover up" and conceal his real feeling. As a consequence of his feelings of guilt and futility, he is apt to conceal his abnormal attitudes and can make a good showing at the time of examination. In order to detect these cases early it is important to bear in mind the possibility that a more malignant disturbance of thought and feeling may underlie an apparently benign depression. The following indications should arouse active suspicion of the presence of a psychotic depression: self-derogatory ideas, an apologetic manner, an attitude of hopelessness or futility, loss of interest or hope for the future, self-blame for inadequacies which may be fancied or due to illness, the persistence of self-deprecatory ideas in spite of logic or reassurance, and the presence of a perplexed or confused state of mind.

The distinguishing feature of the psychotic depression as contrasted to reactive depression lies in the unreasonableness of the self-derogatory ideas, the delusional nature of somatic symptoms, and feelings of guilt and unworthiness. The depression pervades the whole personality and persists with only minor variations in severity from day to day. Environmental factors have very little influence on the state of mind.

Other types of manic depressive psychosis are descriptive of the symptomatology and course of various groups of cases. In the *circular* type, manic and depressive episodes follow one another without an interval of remission. The *stuporous* type is characterized by depression and retardation to the degree of immobility and mutism. The *perplexed* type is characterized by retardation and depression but a chief symptom is perplexity, an attitude of puzzlement which may lead to misinterpretation of events and preoccupation with futile attempts to "figure things out." These patients may have more insight into the fact that they are not well, but are prone to blame themselves for past mistakes and paint an uncomplimentary picture of their past life which is not in keeping with the history obtained from other sources. Such patients are frequently mistaken for cases of schizophrenia. As in any psychosis a careful evaluation of the pre-psychotic personality is necessary.

1522. Schizophrenia (*dementia praecox*)

Schizophrenia is characterized by a primary disturbance in thought content, inappropriateness and shallowness of mood response, with a variable admixture of delusions, hallucinations, loss of contact with reality, poor judgment, lack of insight, and bizarre behavior. Four subtypes are generally recognized: simple, nebephrenic, catatonic, and paranoid, but ordinarily they are not so designated in the diagnostic title.

Frequently attention is called to these patients by bizarre behavior or thought content and there is little difficulty in determining that the patient is psychotic. Occasionally the onset is insidious and the symptoms may not be apparent. The patient may show merely disinterest, apathy, and seclusiveness. Some early cases of paranoid schizophrenia attract little attention by their behavior but may have fixed suspi-

cions and ideas of persecution or grandeur accompanied by emotional reaction of hostility which may cause them to become assaultive or otherwise dangerous. A frequent early sign of schizophrenia is the expression of ideas of reference, particularly those in which the patient feels that he is being watched, talked about, or accused of abnormal behavior such as homosexuality, cowardice, etc.

1523. Paranoia

Paranoia is a rare psychosis characterized by persistent systematized delusions, ideas of persecution, the absence of hallucinations, preservation of clear and orderly thinking and acting, suspiciousness, and lack of insight and judgment chiefly in reference to the delusional system. The chief differentiating features between paranoia and dementia praecox are the absence of hallucinations and the lack of deterioration in the former.

1524. Paranoid State

The term *Paranoid State* is used to designate an illness characterized by a personality change in which attitudes of suspicion and ideas of persecution are present to a degree sufficient to warrant the establishment of a psychiatric diagnosis. These cases must be distinguished from early paranoid schizophrenia. *Paranoid State* may be differentiated from *Personality Disorder* (*Paranoid Personality*) by the fact that the latter title indicates a personality pattern which has been present over a period of years as a personality characteristic of the patient. The title *Paranoid State*, on the other hand, should be used to indicate a pathological change in attitude and thought content not present in the previous personality.

1525. Psychosis With Psychopathic Inferiority

Here should be classified those psychoses occurring in persons whose basic personalities are characterized by a life history of antisocial attitudes and behavior (criminalism, vagrancy, etc.—see 1563, *Constitutional Psychopathic Inferiority*). These psychotic episodes may resemble the classic psychotic states but are of relatively short duration.

1526. Psychosis With Mental Deficiency

Here should be classified those persons with mental deficiency who have psychoses not classifiable in the categories of manic depressive psychosis, schizophrenia, or the organic psychoses.

1527. Psychosis. *Otherwise Unclassified.*

This category should be limited to those psychotic conditions in which the symptom constellation does not fall within the categories defined in the above titles. This title is not a diagnostic category *per se.* Occasionally the need will arise for this classification, usually in those psychoses where there is an admixture of manic depressive and schizophrenic features so that the clinical picture is not clearly defined. In other instances lack of history or an inadequate period of time for observation may justify the use of this title.

1531. Reactive Depression

Here should be classified only those *depressions* which occur in direct and casually related response to adverse environmental situations. The occurrence of an appropriate degree of sadness or a mourn-

ing reaction following a catastrophic event or a distressing situation should not be classified here unless the depression is clearly disproportionate to the event and of unusual duration. Usually a *Reactive Depression* occurs after prolonged or repeated environmental stresses.

Reactive Depression is characterized by psychomotor retardation, disinterest, varying degrees of insomnia, brooding, difficulty in concentration, lack of usual enthusiasm and energy, and pessimism.

1541. Psychoneurosis, Anxiety

This reaction type is characterized by a more or less continuous diffuse state of apprehension or fear, accompanied by the various physiological manifestations of fear, such as excessive perspiration, palpitation, tremors, and gastro-intestinal symptoms. The diffuse anxiety is commonly fixed by the patient upon a bodily symptom or some situation and appears as an inappropriate concern regarding a supposed cause of anxiety such as apprehension and fear of "heart trouble," death, suffocation, or the consequences of some action.

Symptoms differ from case to case and include giddiness, insomnia, nausea after meals, anorexia, heartburn, polyuria, diarrhea, tension, substernal oppression, sighing respiration, headache, fatigue, loss of self-confidence, and difficulty in concentrating.

Anxiety as a symptom may occur in a variety of both functional and organic illnesses. In *Psychoneurosis Anxiety*, however, the apprehension and the related somatic manifestations of anxiety are characteristic and are related to deep-seated causes of anxiety and neurotic mechanisms.

Differential diagnosis.—Other psychoneurotic reaction types may be accompanied by variable degrees of anxiety, but when the chief symptomatology is characteristic of the other reaction types (hysteric, obsessive, compulsive, and neurasthenic reactions), the corresponding diagnosis should be established.

Anxiety symptoms occur in *Fatigue, Combat*, but in addition there appear the characteristic findings of marked startle reactions, terrifying nightmares, varying degrees of retardation, irritability, depression, and a "dazed" appearance that are not usual in *Psychoneurosis Anxiety*. In *Fatigue, Combat*, the symptoms follow exposure to severe and prolonged stress in battle and subside to a great extent when these stresses are removed.

In consideration of the diagnosis is *Psychoneurosis, Anxiety*, care must always be taken to rule out an organic disease which may be present concurrently or as the cause of the anxiety symptoms (e. g. hyperinsulinism, hyperthyroidism, organic neurological disease).

1542. Psychoneurosis, Hysteria

A characteristic feature of this psychoneurotic type is the conversion of anxiety to somatic symptomatology, characterized by varying manifestations of loss of function of a part. There is usually a dissociation of the basic anxiety and tension so that the patient is relieved of the emotional turmoil and becomes preoccupied with the bodily symptoms which assume a relatively fixed pattern. In most instances, there is an admixture of both anxiety and physical manifestations such as pseudo-convulsions and nonorganic deafness, blindness, paralysis, contracture, or peripheral sensory changes. Amnesia, trancelike episodes, and fugue states may occur. Although these states may or

may not be associated with conversion phenomena, the hysterical personality pattern is characteristically present. These states must be differentiated from epileptic equivalents and amnesic states which occur in organic brain disease.

1543. Psychoneurosis, Obsessive Compulsive

A synonym for this diagnosis is *Psychoneurosis, Psychasthenia.* This condition is characterized by a compulsive need to perform certain acts (rituals, ceremonials) and accompanying anxiety, especially when these compulsive tendencies are opposed. It is further characterized by obsessive thoughts, usually systematized and consisting of specific phobias (fear of high places, close spaces, open spaces, etc.). These phobias are associated with deep-seated conflicts and are apt to result in compulsive involuntary urges to escape from situations which precipitate the fear reactions.

1544. Psychoneurosis, Neurasthenia

This diagnostic title is applied to those psychoneurotic reactions characterized by lack of energy and initiative, lassitude, mental and bodily fatigability, and diminished power of concentration, usually accompanied by concern over minor bodily symptoms. Most individuals exhibiting hypochondriasis will be classified here. Early schizophrenia, mild depressions, and somatic disease of insidious onset may simulate the neurasthenic syndrome.

1545. Psychoneurosis. *Otherwise Unclassified*

Psychoneurotic reactions which do not clearly fall into the above classifications should be listed as *Psychoneurosis, Otherwise Unclassified.* This title should not be used as a diagnostic category *per se*, but only when the psychoneurotic reaction type cannot be classified. In atypical or mixed syndromes, the psychoneurosis should be classified according to the predominant reaction type.

1561. Personality Disorder

There are a number of patients coming under the cognizance of the Medical Department who have no physical disease, are not psychotic, and do not fall within the category of the psychoneuroses. These patients have been formerly classified as having constitutional psychoapathic states of various subtypes, and constitutional psychopathic inferiority without psychosis. Inasmuch as the connotation of "constitutional psychopath" refers to persons exhibiting distinctly antisocial, amoral, or criminal tendencies, there is a need for a diagnostic term to designate the instances of lesser adjustment difficulties where inadequacy in adaptation is the primary feature. Inadequacy as defined by the needs of the naval service may be noted in men who, under the less rigorous conditions of civilian life, are able to make a more or less satisfactory adjustment although the personality characteristics which result in the maladaptation to military life were present in their preservice life.

These individuals may manifest their personality disorders by emotional instability, inadequacy, maladjustment, eccentricity, impracticality, resentful or mildly paranoidal attitudes, moodiness, irritability, impulsive behavior. Although these personality characteristics are commonly considered to be "constitutional" in origin, this diagnostic title shall include the acquired personality disorders

following intracranial injury and encephalitis. There may be added a qualifying phrase indicating the type of personality disorder (viz: emotional instability, inadequate personality, cyclothymic personality, paranoid personality, post traumatic, post encephalitic, e.g., Personality Disorder, emotional instability, 1561), although for purposes of classification and disposition a subtitle need not be used.

Emotional inflexibility (as a lifelong pattern) in the older age group should be classified here. Emotional immaturity of the teen ages when merely a reflection of the youth and inexperience of the individual should more properly be classified as No Disease (*not adapted to naval service*). In consideration of the differential diagnosis, reference should be made to the discussion of the related titles of *Constitutional Psychopathic Inferiority*, *Schizoid Personality*, *Pathological Sexuality*, and *Paranoid State*. In distinguishing between the diagnosis *Personality Disorder* and the title *No Disease (not adapted to naval service)*, it is to be noted that the *No Disease* title implies no personality disorder in the longitudinal or "constitutional" sense but indicated an inability to adapt satisfactorily to the circumstances of the naval service. In the case of the personality disorder the history should reveal evidences of the observed personality pattern in the individual's past life.

Schizoid Personality

This title may be used to indicate a personality disorder in which the pattern of attitudes, behavior, and ideation is manifested by seclusiveness, shyness, tendency to fantasy and day-dreaming, bizarre ideas, inadequacies in social relationships, extraordinary religious interests, and a paucity of emotional response, without evidence of psychosis. Care should be taken to make the distinction between the diagnosis and simple schizophrenia or *Personality Disorder*, *Inadequate Personality*. Occasionally, an atypical mild psychosis may simulate a personality disorder when its onset is insidious and by the presence of symptoms of seclusiveness, disinterest, perplexity, and lack of initiative and force.

Frequently a person with a *Schizoid Personality* (or any personality disorder) as a result of his difficulties in adjustment will first come to the attention of the medical officer because of anxiety, restlessness, irritability, etc. In this event, these situational reactions are often merely symptomatic of the basic disorder. Usually the personality disorder is disclosed when the past history is obtained and after careful study of the background factors.

As in the case of all personality disorders, a necessary feature of this classification is that there should be a longitudinal picture of the personality characteristics rather than evidence of a recent change superimposed upon a previously normal personality.

1563. Constitutional Psychopathic Inferiority

In contrast to the type of behavior disturbance described above under *Personality Disorders*, the designation of *Constitutional Psychopathic Inferiority* should be utilized for those cases exhibiting distinct antisocial, amoral and criminal personality characteristics. Here may be classified the pathological liar, the vagrant, the nonconformist and other criminal types. The personality structure of these individuals is characterized by an incapacity to profit by experience, impulsive

erratic behavior, resentment of authority, erratic judgment, independability, and an inadequate development of moral sense.

1564. Pathological Sexuality

This classification may be used in those cases where verified sexual deviations constitute the essential clinical picture (i. e. homosexuality, exhibitionism, transvestitism, etc.). In all cases careful substantiation by documentation is necessary to establish this diagnosis. It should be remembered that in many instances a patient will give a history of sexually aberrant behavior or tendencies which are symptomatic of his illness, as in depressions: (exaggerated guilt feelings), schizophrenia (delusions of persecution or bizarre ideas). As the basic psychiatric disability may not be obvious, care must be taken to determine that the sexual aberration is not the result of an underlying illness.

Not uncommonly, careful psychiatric inquiry will reveal sexual conflicts on a nonconscious level existing as factors underlying psychoneurotic reactions. However, in recording the sexual history or such indirect evidences of sexual conflict, care should be taken to avoid unjustified inferences or conclusions.

1571. Speech Disorder

This designation replaces the former diagnosis *Stammering 1761* and *Stuttering 1762*. Whenever possible a diagnosis indicating the underlying cause of the speech disorder should be used.

1572. Alcoholism, Chronic

Alcoholism is usually a symptomatic expression of an underlying personality disorder or psychoneurotic reaction. The patient with a history of excessive indulgence in alcohol over a long period of time in addition usually demonstrates a certain disintegration of personality, unreliability, egocentricity, and maladjustment. Defensive attitudes, a tendency to projection, irritability, and marital maladjustment are common. These personality defects and maladjustments may be considered in some instances as results of alcoholism, but commonly they represent a basic disorder of which resort to alcohol is the most obvious symptom. An effort should be made to disclose the underlying cause prompting recourse to alcohol for symptomatic relief or psychological escape. Psychiatric disabilities which may frequently manifest themselves in over-indulgence in alcohol are: manic depressive psychosis (especially hypomania and depression), obsessive compulsive psychoneurosis, constitutional psychopathic inferiority, personality disorders, and maladjustment in certain extrovert types of personality not prone to the expression of conflict in psychoneurotic reactions of anxiety, hysteria, neurasthenia, or depression when under stress. Alcohol is their "escape" and the usual neurotic manifestations may not be overtly present. In most cases it can be shown by careful psychiatric evaluation that the basis of the abnormal behavior is similar to that underlying psychoneurotic reactions generally. This is not to say that such a patient is free of guilt in relation to any misbehavior resulting from over-indulgence. However, the passing of a moral judgment is outside of the province of a medical diagnosis.

1573. Enuresis

Here should be classified those individuals in whom bed wetting is the major symptom of their behavior maladjustment. It is recognized that there is a small percentage of cases wherein there exists an organic defect of the genito-urinary system. However, in the majority of instances enuresis occurs as a functional disorder.

1574. Somnambulism

Here should be classified those cases of persistent sleep-walking unaccompanied by other evidences of psychoneurosis or personality disorder sufficient to justify the establishment of a diagnosis indicative of the underlying disturbance.

1581. Mental Deficiency

This title may be used in those cases where the intellectual capacity is below the prescribed requirements and substantiated by standard psychometric tests. Care should be taken to ascertain that the psychometric findings represent a true measure of mental capacity rather than a mere reflection of illiteracy, educational handicap, or mental illness.

15xy. *Other Disease of This Class*

This number is provided in order to allow the diagnosis of a disease entity not otherwise designated in the nomenclature. As the nomenclature is both comprehensive and elastic, it is anticipated that the need for an unlisted diagnosis will be encountered infrequently. This category should not be utilized to describe a particular manifestation of a listed disease entity, nor should it be used to indicate a specific sub-classification or variant of one of the standard titles.

For reasons of classification, statistical study, uniformity and occasionally for medical-legal reasons, the use of the 15xy designation should be limited as much as possible.

A discussion of the diagnostic titles designating the Diseases of the Nervous System (Class XVII diagnosis) is not contemplated with the exception of the diagnosis *Epilepsy 1714.*

1714. Epilepsy

Grand Mal.—The Chief criterion for the use of this title shall be the occurrence of a typical convulsive seizure for which no cause can be found. The accurate description of the convulsion as observed by a competent witness shall be recorded in the health record. Care should be taken to obtain all the facts available in order to make possible a clear differentiation between epilepsy and other conditions which may be manifested by unconsciousness and convulsions. Hysterical convulsions. Hysterical convulsions may closely simulate *grand mal.* Syncopal attacks are occasionally accompanied by convulsive movements of the extremities, frothing at the mouth, and transient neurological findings.

Before the diagnosis of *Epilepsy* is established, a thorough study to rule out the possible causes of a convulsive seizure should be completed. Among these causes are brain tumor, brain abscess, cerebral arteriosclerosis, encephalitis, circulatory disturbance, multiple sclerosis and other organic diseases of the brain.

EEG may provide valuable confirmatory data when the record is unequivocal. However, an EEG record of 'epileptic type' should not be made the basis of this diagnosis without a history of a true seizure and one or more of the cardinal signs of a grand mal convulsion (in addition to tonic and clonic movements), viz, aura, cry, incontinence, biting of the tongue, or scars on the tongue.

Petit mal.—Although the typical case is quite characteristic care must be taken to distinguish between petit mal, narcolepsy and transient 'spells' occasionally associated with organic neurological diseases. Ideally, this diagnosis should be confirmed by the findings of characteristic abnormalities in the EEG. However, as in the grand mal, care should be taken to avoid placing too much reliance on the EEG records when not adequately supported by clinical findings.

Epileptic equivalents.—Transient states of sudden onset characterized by a state of confusion, automatism, or abnormal behavior pattern without loss of consciousnes. These states must be distinguished from hysterical fugue and amnesia, toxic delirium and transient psychotic episodes due to various toxins. Careful investigation and accurate recording are of particular importance because of the possible medico-legal implications. Positive EEG findings are of confirmatory value and may be of great importance, particularly if a record can be obtained during the episode, demonstrating the characteristic abnormalties at that time.

2143. No Disease

The use of the diagnostic term *No Disease* in connection with the disposition of personnel on Reports of Medical Survey has been fully discussed in BuMed letter (BuMed-RP-IMB, P3-5/P19-1, 25 April 1945). This letter is repeated herewith with some minor alterations consistent with the recent changes in the psychiatric titles of the diagnostic nomenclature.

Ref: (a) Manual of the Medical Department, app. A.
(b) Manual of the Medical Department, par. 2402 (e).

1. It is recognized that there are noneffective personnel in the service in whom organic pathology cannot be demonstrated and who do not show evidence of a bona fide psychiatric disability. When these individuals are referred to the Medical Department for evaluation and it is determined beyond any reasonable doubt that they are noneffective, but have no physical or mental disability of sufficient significance alone to preclude their return to duty, the diagnostic title *No Disease* may be utilized to effect their separation from the service.

2. Reference (*a*) and (*b*) provide for the use of the diagnostic title *No Disease* in the case of personnel who for some reason are carried on the sick list, but who do not claim to be sick and who are not regarded as sick. The information contained in this letter is presented for the guidance of medical officers and of boards of medical survey in connection with the separation of personnel from the naval service under the diagnosis *No Diseases.*

3. Noneffective personnel comprise a heterogenous group which in general is made up of men who have had service beyond the recruit period and who may be classified within the following four subgroups, each of which is ineffective for totally different reasons.

(*a*) Those personnel in the older age groups whose ineffectiveness has resulted from the physical limitations and mental inelasticity normal for their age. The ineffectiveness of these individuals is not the result of disease, but represents the physiological limitations of physical and mental adaptability commonly found in older age groups. These individuals are at a disadvantage and may become noneffective in attempting to keep pace with the younger, more vigorous and more adaptable men.

(*b*) Those individuals who have performed stressful duty and do not have any physical or mental disability which is alone sufficient to preclude their return to duty, but who should not be returned to duty as a matter of preventive psychiatry. These individuals have previously rendered effective service but have sustained a reduction in their efficiency to the point of military noneffectiveness by reason of the prolonged stressful duty or situational factors which they have encountered in the service. These individuals can be expected to readjust to civilian life without residual evidence of disability.

(*c*) Those individuals whose demonstrated ineffectiveness is evidence of domestic, marital, or economic difficulties which cannot be solved if the individual is continued in the service, but whose symptomatology is not sufficiently characteristic or of sufficient magnitude to warrant a diagnosis of Psychoneurosis.

(*d*) Those individuals who are ineffective by reason of their inability to accept responsibility, to make satisfactory social adjustment, and to integrate themselves with the group. Prominent among these individuals are those with a certain degree of inadequacy or a minor degree of instability which is insufficient to interfere seriously with civilian adjustment, but which is of sufficient degree to result in noneffectiveness in the service. It must be recognized that many individuals in the population may evidence degrees of inadequacy and instability in specific military circumstances, who nonetheless have established entirely satisfactory adjustments in nonmilitary environment. Such ineffective personnel, who evidence minor degrees of inadequacy which are frequently reflected as minor evidences of instability in isolated spheres, should not be given a diagnosis of *Constitutional Psychopathy*, or other diagnosis indicative of personality disorders, but should be recommended for discharge under the diagnosis *No Disease.*

4. As set forth in reference (*a*) and (*b*), the reason for the use of the diagnostic title *No Disease* shall be recorded. In most instances the reason for its use in the case of noneffective personnel can be given as follows:

No Disease (*Not Adjusted to Service*) or (*Temperamentally Unsuited for Service*); or

No Disease (*Unable to Adjust Further to the Demands of the Service*);

or

No Disease (*Unsuited for Further Useful Service*).

5. When careful history, social-service reports, examination, observation, and all other psychiatric aids clearly indicate that the individual has demonstrated lifelong behavior characterized by inadequacy and instability in nearly all fields of behavior or in one field of behavior to a pathological degree, the appropriate psychiatric diag-

nosis shall be given. This type of individual should not be diagnosed *No Disease*. Where the history and psychiatric examination are diagnostic of *Personality Disorder or Phychoneurosis*, the appropriate diagnosis which indicates the nature of the disability shall be used. Similarly, when medical or surgical disabilities exist and are of sufficient significance to preclude return to duty, such disabilities shall be appropriately diagnosed despite the fact that the individual otherwise falls into the class of noneffectives.

6. It should be noted that when lifelong abnormal behavior is antisocial, egocentric, and unaltered by experience, the diagnosis of *Constitutional Psychopathic Inferiority* should be made. If the history is such that the outstanding characteristics are not primarily antisocial but rather those of inadequacy, the diagnosis *Personality Disorder* should be utilized rather than the diagnosis *Constitutional Psychopathic Inferiority*.

7. In the disposition of the noneffective personnel under the title *No Disease*, care and judgment are required to determine the noneffectiveness and absence of disabling physical or mental disease. However, once it is the opinion of a board of medical survey that the individual had no such disease but is a noneffective, the recommendation for separation from the service under the diagnosis *No Disease* is appropriate. The report of medical survey should include such facts in the body of the survey as clearly support the opinion of the board relative to the absence of incapacitating disability and the presence of noneffectiveness.

8. When reports of medical survey are submitted in accordance with the above and are approved by this Bureau, they will be forwarded for appropriate action to the Bureau of Naval Personnel or Commandant, Marine Corps, who have expressed the intention of following a policy in general of discharging such personnel under honorable conditions provided the service record warrants. Personnel so discharged will retain the privilege of wearing their uniforms. It is further the expressed intention of the Bureau of Naval Personnel and the Marine Corps that officers who are separated from the service under this diagnosis will be given an opportunity to resign, or will be released from active duty and/or discharged if they do not elect to submit their resignation.

—BUMED, ROSS T MCINTIRE.

It should be stressed that the *No Disease* diagnosis must be strictly limited to those instances when, after careful search and study, no physical or psychiatric disability is disclosed. All such cases should have a careful psychiatric examination to eliminate the possibility of psychiatric disability before discharge is recommended. Careful evaluation is particularly needed in subgroups B—those individuals who have performed stressful duty but who are no longer adapted to naval service. This group should not include those persons who have sustained a reduction in their efficiency due to any physical or psychiatric disability. The reaction to prolonged stressful duty which renders them ineffective for further military duty should be rather the result of a reduction in motivation, or of conditions which have not resulted in disability, but which in the opinion of the examining medical officers are likely to result in a disability if the man continues on duty.

In subgroup D, recognition is given to the fact that there are persons who are within the range of normal (i. e. have no disease or personality disorder), who make adequate civilian adjustments, but are unable to adjust effectively to the demands of military life.

The dianosis of *No Disease* has been in use as described in the Manual of the Medical Department, paragraph 2402 (e), and should not be considered to be a psychiatric diagnosis. However, in utilizing the category of *No Disease* as described above, the elimination of physical disease alone is insufficient, as there may be present a psychiatric disorder for which the man should receive a medical discharge. Hence the psychiatric examination of such cases is essential.

GLOSSARY

Affect	A term denoting emotional response and including all subjective feeling tones.
Ambivalence	Refers to the concept that each feature of the personality has a double aspect, an opposite counterpart closely connected with it. In effective ambivalence contradictory feeling attitudes may exist toward the same object. One component is ordinarily repressed.
Amnesia	Loss of memory for experiences and events during a circumscribed period of time.
Anxiety	A persistent feeling of apprehension and dread arising from threats of which the person is unaware, accompanied by a painful uneasiness of mind and vague anticipatory ideas of harm or disaster.
Autistic Thinking	Fantasy thinking, daydreaming to the exclusion of reality. Its synonym, dereistic thinking, has come into more common use.
Blocking	An interference in the trend of thought due to the intrusion of an emotionally 'charged' association. This may be manifested to a sudden obstruction of the flow of speech.
Catalepsy	A constantly maintained immobility of position. In waxy flexibility, the joints of the extremities may be moved by the examiner and will remain in the new position.
Cataplexy	The sudden loss of power and tone of all skeletal muscles under the influence of emotional excitement, usually laughter.
Circumstantiality	A mental symptom marked by conversion in which the goal-idea is reached only after relating many irrelevant details.
Compulsion	A compelling impulse to perform some act contrary to one's better judgment or will, undertaken in an attempt to allay anxiety.
Confabulation	A symptom of various psychoses wherein the patient, upon suggestion, recites imaginary experiences as true, by way of a compensatory substitution for loss of memory, to fill a memory gap.
Delusion	An emotionally conditioned false belief resulting from illogical inferences, or from logical inferences based upon false premises which cannot be corrected by argument or persuasion. A mistaken conviction which even the evidence of the patient's senses will not remove.
Depersonalization	Loss of the sense of personal identity. A feeling of being someone or something else.
Dissociation	A disorder of thinking in which one or several groups of ideas become split off from the main body of the personality and are not accessible to the conscious mind. Disparity between the intellectual and emotional life, as in dementia praecox. Dissociation may be partial, as in hysteric fugue, or complete, as in double personality.
Emotion	A state of excitement characterized by a strong feeling tone. Any one of the states designated as fear, anger, disgust, grief, joy, surprise, yearning, etc. The physiological responses occurring in connection with some instinctive emergency behavior of the organism.
Fugue	A period of amnesia during which the subject conducts himself in an apparently normal fashion in activities dissociated from his usual pattern.

Flight of Ideas	A disturbance of the train of thought by over-ready responses to associations and to external or internal stimuli, producing digressions which prevent the reaching of the goal-idea of a narrative.
Hallucination	A false sensory perception not founded upon objective reality referred to one of the special sense organs (hearing, smell, etc.)
Homosexuality	Having a personality pattern characterized by a fixation at, or reversion to, a stage in sexual development in which interests are predominantly directed toward those of the same sex. When used more specifically, or as a noun, the term refers to persons who seek sexual relations with members of the same sex, or to such acts.
Hostility	Aggressive antagonism, open or concealed, which may or may not be shown in outward acts or recognized by the subject.
Ideas of Reference	An unwarranted belief that certain actually neutral events have special significance and are directed toward him.
Ideas of Persecution	Ideas resulting from the patient's belief that he is the actual or intended victim of hostile acts of others.
Illusion	A false interpretation of a real sensory image.
Impulsion	An abnormal impulse to perform certain acts, usually of a disagreeable nature.
Mannerism	A persistent stereotyped modification of ordinary behavior; peculiarity of gesture, bearing or gait; an affectation of manner.
Mental Responsibility (Competence)	The ability to comprehend and fully realize the nature and quality of one's acts. Possession of normal good judgment and reason.
Obsession	An idea which morbidly dominates the mind, suggesting irrational action.
Phobia	A fixed morbid fear usually related to a specific object or circumstance.
Preoccupation	State of being absorbed in one's own thoughts oblivious to one's surroundings.
Retardation	Pathological slowness or delay of mental or motor responses.

OUTLINE FOR EXAMINATION OF NEUROPSYCHIATRIC CASES

The necessity of following some plan or method of case-study in psychiatric work is universally recognized. The outline presented below represents the minimal requirements for a routine neuropsychiatric examination. It lists the various topics which should be covered by appropriate inquiries, if cases are to be adequately and completely studied. Common sense and judgment, of course, must be used in deciding the amount of detailed investigation required in any case. It is not desired to lay down hard and fast rules to the extent of suppressing originality. This outline, therefore, is to be regarded merely as a guide. Uniformity in the method of approach and in recording findings is desirable for many reasons, and it is hoped that this outline will be followed wherever possible in writing up neuropsychiatric cases in health records.

I. Chief Complaint

Predominating subjective symptoms for which the patient seeks medical attention recorded verbatim in his own words.

II. Present Illness

The story of what the patient has experienced and what has been noted about him by others. Arrange the facts elicited chronologically as far as possible. Describe briefly the incident or problem and the symptoms which marked the beginning of his difficulty. Give the date and place of onset. A statement regarding the surrounding circumstances of the onset and the setting in which it occurred is particularly important. Note the progress and development of subsequent symptoms in the order of their appearance, step by step.

III. Personal History

1. *Early development*—Birth injuries and deformities. Age at walking and talking. Neurotic traits. Childhood characteristics.
2. *Home environment*—Family harmony. Attitude toward parents and siblings. Treatment by parents and others. Broken home. Conflicts with stepmother or father. Ran away from home. Reasons.
3. *Education*—Final grade completed. At what age. Progress. Reasons for failures. Conflicts with teachers and schoolmates. Truancy. Reasons for leaving school.
4. *Industrial*—Positions held. Wages received. Length of time in each. Efficiency at work. Economic adjustment.
5. *Past Medical*—Diseases, injuries, and operations from infancy to present time in chronological order, with particular reference to previous attacks of mental illness or nervous disorder.
6. *Habits*—Use of, and reaction to alcohol. Habits regarding diet, tobacco, coffee, sleep, exercise, recreation, etc.

7. *Sex Life*—Excessive or prolonged masturbation. Associated conflicts and guilt feelings. Any changes in sexual powers or interests. Impotence. Homosexual tendencies or overt acts. Perversions.

8. *Marital*—Date of marriage. Health of wife. Number of children. Still births and miscarriages. Any sexual incompatibility. Domestic conflicts and dissensions. Separation or divorced. Reasons.

9. *Antisocial conduct*—Juvenile offenses. Residence in reformatory. Attitude toward authority. Arrests in adult life. Prison and jail sentences. Nomadism, hoboism, and tramp life.

10. *Military*—Active combat experiences. When and where. Courts martial. For what offenses. Any disciplinary action pending. Attitude toward the service. Promotions. Special duties. Previous service in Army, Navy, or Marine Corps. Dates. Reasons for discharge.

IV. Preillness Personality

Information should be obtained regarding main hobbies and interests, output of energy, moods, general relationships with other people, sociability, seclusiveness, ambitions, likes and dislikes, affiliation with religious cults, eccentricities, tolerance, conscientiousness, sensitivity, sense of humor, rigidity and perfectionism, and feelings of inadequacy and inferiority.

V. Family History

Note the presence of mental disease, neurological disorders, chronic invalidism, neurotic traits, epilepsy, criminality, suicide, drug addiction, and alcoholism in the parents, brothers, sisters, and collateral lines.

VI. Physical Examination

It cannot be too strongly emphasized that all psychiatric patients require a thorough examination. Use the outline scheme of physical examination with which you are familiar.

VII. Neurological Examination

The general physical examination should be supplemented by a neurological examination in every case. The following represents the the minimum requirements for a routine neurological examination. Carry out additional tests, if indicated.

1. *Cranial nerves*—Fundi. Ocular movements. Pupils for size, shape, outline, direct and consensual light reflex, and accommodation for near and distant vision. Nystagmus. Corneal reflex. Jaw jerk. Jaw movements. Facial movements. Ask about tinnitus, deafness, dizziness, and vertigo. Difficulty in swallowing. Palatial reflex. Head and shoulder movements. Protrusion of tongue.

2. *Speech*—Ordinary conversation. Test phrases.

3. *Motor system*—(*a*) Gait; (*b*) Romberg; (*c*) finger, nose and heel-knee tests; (*d*) tremors; (*e*) atrophies: fibrillations; (*f*) tone; (*g*) strength of grips and flexors and extensors both wrists and ankles; (*h*) paralysis.

4. *Reflexes*—(*a*) Triceps, biceps, radial, patellar, achilles and ankle clonus; (*b*) abdominal, cremasteric, plantar and Babinski.

5. *Sensory system*—Rough orientation as to (*a*) light touch; (*b*) superficial pain; (*c*) temperature only if there are any subjective complaints; (*d*) joint position sense; (*e*) vibratory sense.

VIII. Mental Examination

The following guiding principles may be outlined: (*a*) It is essential to interview the patient privately. (*b*) The patient should be approached in a friendly way. Tact and gentleness are essential. (*c*) Describe and present facts accurately. Get unequivocal statements, if possible. (*d*) Avoid all terms open to confusion. It is best to resort to a plain statement of events in simple, nontechnical language. (*e*) All entries should be as objective as possible with a minimal amount of interpretative discussion and impressions of the medical officer. (*f*) It is especially desirable to give in the patient's own words examples of his delusional ideas or hallucinatory experiences. (*g*) The mental examination should not be postponed because the patient is acutely disturbed, stuporous, or for other reasons noncooperative.

A general statement may be all that is required to describe the mental examination of many patients, but usually some comment regarding each of the following subheadings is useful, whether itemized as such or incorporated in a running description.

1. *Appearance and behavior*—Condition of hair and clothes. Dress. Personal cleanliness. Facial expression. Reaction to examination. Accessibility, mannerisms and conduct.

2. *Stream of talk*—Accelerated, slow, or retarded. Note abnormalities such as volubility, mutism, circumstantiality, flight ideas, distractibility, blocking, incoherence, neologisms, preservation, verbigerations, and echolalla. Verbatim samples are often of value and should be incorporated if any peculiarity is present.

3. *Emotional reaction*—Objective signs of emotion. Expression of subjunctive feelings. Specfic inquiry regarding mood and spirits. Prevailing mood. Fluctuations in mood. Inappropriate emotional reactions.

4. *Content of thought*—Obsessive-compulsive trends, including phobias, doubts, preoccupations, rituals, impulsions. Hypochondriacal ideas. Hallucinations. Ideas of reference. Delusions, including paranoid, self-accusatory, grandiose, feelings of alien control or passivity, feelings of unreality, and depersonalization. Day dreaming. Unusual or peculiar dreams.

5. *Sensorium*—(*a*) Orientation as to time, place and person. (*b*) State of consciousness. (*c*) Comprehension or ability to take in and understand meaning of questions and incidents in the environment. (*d*) Attention easy or difficult to obtain, readily held or wandering.

6. *Mental capacity*—(*a*) Memory for remote and recent events. Confabulations, retrospective falsifications, and periods of amnesia. (*b*) Retention and recall. Tested by repetition of digits and recalling a name or address. (*c*) Calculations. Simple tests in multiplications. addition, division, and subtraction. Need not be given to adults of average intelligence unless there is evidence of mental deterioration or intellectual impairment. (*d*) Judgment and reasoning. This may be estimated by what has gone before in the examination. (*e*) General information. Estimated by responses to questions asked concerning current events, history, and geography. Due regard should be given to his education, nationality, and experience. (*f*) Insight. The degree to which the patient realizes his condition and the nature of his disorder.

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